Reference Number:	734-01-DD
Title of Document:	Individual and Family Support Stipend and Respite – State Funding
Date of Issue:	August 8, 1989
Effective Date:	August 8, 1989
Last Review Date:	~~January 21, 2009~~ July 1, 2010 **(REVISED)**
Date of Last Revision:	~~February 1, 2009~~ July 1, 2010
Applicability:	Central Office; DSN Boards; Contracted Service Providers

---

The Department recognizes that families are the greatest resource available to individuals with disabilities. They should be supported in their role as primary caregivers and be provided the assistance needed to care for their family member at home, if possible. The Department further believes that it is more efficient, cost effective and humane to support consumers and families in their efforts to care for their family members at home.

DEFINITION OF FAMILY

A "family" is a DDSN eligible person with a disability and the parent(s), sibling(s), relative(s), or other caregiver who reside in the same household or a DDSN eligible person with a disability who lives with or without the support of others.

PURPOSE/OBJECTIVE

The purpose of Individual and Family Support and Respite (IFS-R) funding is to provide assistance to families in caring for a DDSN eligible person with mental retardation or related disabilities, autism, or ~~head~~ traumatic brain injury or spinal cord injury or similar disability in order to avoid out-of-home placement. Priority will be given to:

1. Those families who are exhausted due to the direct, hands-on care and supervision of the consumer.

2. Consumers or their families who, without the IFS-R, would likely be in an unsafe, risky or dangerous situation. ~~If not for these resources or services the individual is at risk of out-of-home placement. This consumer's f~~

Funding is directed toward consumers or families who can care for themselves at home, but incur additional expenses due to the disability and not for any consumer residing in any DDSN residential facilities or receiving DDSN operated HCB Waiver services. This funding should be used for needs that are not incurred routinely by families with non-disabled individuals.

Those consumers in critical circumstances (on critical needs waiting list) or at significant risk for placement on the critical needs waiting list (even after provider has made efforts to address the situation) will have access to "crisis stabilization funds" managed by DDSN District Offices. See directive 502-05-DD: DDSN Waiting Lists, for criteria and procedures ~~should be given priority to receive IFS funds~~.

In accordance with state law, IFS-R is not an entitlement program or a general public assistance benefit. IFS-R should be time limited and should not be ongoing except in rare ~~for~~ circumstances. ~~that document financial need as well as to avoid out of home placement. An evaluation should take place every six months to ensure funds are necessary based on financial needs and the avoidance of out-of-home placement is still prevalent.~~ Careful monitoring of these situations is required.

STATE FUNDING AND APPROVAL REQUIREMENTS

Annually each DSN Board is given an award for family support stipends and respite. **All consumers receiving services from private qualified providers will be given fair and equal access to these funds**. This award should be used strictly for services with no administrative cost being allocated to the ~~family support~~ IFS-R award. ~~When reviewing requests for funding approval, consideration must be given to existing commitments, interpreter services, as well as future requests.~~

IFS-R should only be made available to the consumer or family, when needed goods or services cannot be funded by other public agencies or community resources or through other DSN services/programs. Documentation of these efforts must be included in the request for IFS-R ~~family support funding. IFS should only be used for respite and summer services when local respite and summer service funds have been exhausted.~~

Requests to assist families with routine costs of daily living (rent, utilities, food, clothing, etc.) should be approved only in extreme or unusual circumstances and after careful review.

As part of the review of consumer needs, ~~these~~ additional points should be considered.: If Supplement Security Income (SSI) is received, this income should be used for the consumer's needs and not for general expenses of other family members. Household expenses can be categorized into essential and non-essential. Essential expenses are shelter, food, utilities, and other similar necessary expenses. Non-essential expenses are luxury items not related to routine daily living or other optional expenses. An example of a non-essential expense is cable/satellite TV. There are many expenses a person with a disability will incur that are related to the

disability; however this does not mean that these expenses should be routinely covered unless there is documentation that these expenses exceed the family's ability to pay (e. g., an individual who has medical equipment that uses electricity and a notice that power is to be cut off has been received – approval may be given if documentation indicates how this will be avoided in the future).

~~Allocation of funding should be prioritized to assist families with the greatest needs that are related to the person's disability and if not provided, are likely to result in out-of-home placement. There are many expenses a person with a disability will incur that are related to the disability; however this does not mean that these expenses should be routinely covered unless there is documentation that these expenses exceed the families' ability to pay (e. g., an individual who has medical equipment that uses electricity and a notice that power is to be cut off has been received – approval may be given if documentation indicates how this will be avoided in the future).~~

DSN Boards are required to maintain a log on all requests received. This log should include name of consumer, requested item, requested amount, and approval/disapproval and reason for approval/disapproval. This reason must be supported by the Board's IFS-R policy. ~~family support policy~~. ~~It should be readily available if requested.~~ The log must be submitted to the appropriate District Office on a monthly basis. It is due by the 10th of the month following the approval/disapproval.

~~Eligible to Receive IFS~~

- ~~DDSN eligible persons to include those consumers in an "MR time-limited" or "Autism time-limited" category.~~
- ~~People applying for DDSN eligibility who require interpreter services and children birth to three years old not receiving BabyNet services.~~
- ~~High risk infants' ages birth to three years old, to cover services not provided by BabyNet.~~

NOT ELIGIBLE TO RECEIVE IFS-R

- Those who are not eligible for DDSN services ~~(except for those applying for services who need interpreter services).~~
- Those who are enrolled in DDSN operated HCB Waivers ~~(HASCI Waiver recipients who have dental or vision needs can request IFS funding)~~.
- Those who are eligible for DDSN services in the "At-Risk" category (children three (3) to six (6) years) ~~except for providing interpreter services~~.
- Individuals applying for Medicaid through TEFRA ~~level of care~~ and child's only involvement with DDSN is for assistance with the Level of Care process.

PRIORITY OF REQUEST APPROVALS - WHEN CONSIDERING THE PRIORITY TO BE GIVEN TO REQUESTS FOR IFS-R, THE FOLLOWING CIRCUMSTANCES SHOULD BE GIVEN THE GREATEST PRIORITY

- ~~Life/Safety Issues of Consumer/Family~~
- ~~Temporary/Emergency care of Consumer~~
- ~~Critical Circumstances (DDSN Critical Waiting List for Services)~~
- ~~Behavioral Issues likely to jeopardize in-home placement~~
- ~~Extreme Special Circumstances~~

1. Those families who are exhausted due to the direct, hands-on care and supervision of the consumer.

2. Consumers or their families who, without the IFS-R, would likely be in an unsafe, risky or dangerous situation.

~~The Major Allowable Service Categories include the following:~~

- ~~Interpreter services (initial visit and on-going) must be provided if needed. Sufficient funding must be maintained at all times to cover this need. Failure to maintain adequate funding may result in the Board having to use regular operating funds to cover expenditures.~~
- ~~Personal Care/Attendant Care~~
- ~~Respite Care (once respite allocation is depleted)/Sitter Services for MR/RD consumers. There is not a separate allocation of funds for respite for HASCI consumers. Respite needs for HASCI consumers are funded through HASCI family support awards.~~
- ~~Environmental Modifications/Assessment~~
- ~~Assistive Technology/Assessment~~
- ~~Child Care Cost related to the additional expense due to the child's special need~~
- ~~Medical Care, Behavioral Health, Allied Medical Care and Medical Supplies; age and medical condition causing incontinence should be considered before authorizing funding of diapers.~~

~~**NOTE:** IFS funds can be approved for treatments, therapies, and medications which have clinical, peer-review research to support their effectiveness and which DDSN supports. (For example, DDSN has supported limited funding of Applied Behavioral Analysis (ABA) if not already being provided through BabyNet, the public school system, the PDD Waiver or PDD State funded program.)~~

APPLICATION FOR IFS-R

The following must be used in requesting IFS-R funds from state funds. All information requested below must be included as part of any request for IFS-R. DSN Boards can use the attached forms or create their own forms provided that the same information is incorporated.

1. *INITIATING A REQUEST*

A. The service coordinator/early interventionist (SC/EI) identifies the consumer's or family's need for assistance during the assessment or planning process or as a result of the consumer's or family's situation changing during the year.

B. The consumer's Plan and other documentation must be included with the request and must include the specific goods or services needed and justification of the need for the service(s) with specific information to show how the cost requested was determined. A description of the services must be provided as well as documentation showing that all local resources have been exhausted and the financial means test justifies the request.

C. Form #350, *"Request Form – Individual and Family Support Stipend/Respite"*, which includes financial information, must be completed by the SC/EI and signed by the parent, guardian, or consumer. A copy of a current pay stub or other means of verifying both earned and unearned income must be included for all adult household members (i.e., SSI amount, income tax form). Use of the consumer's SSI and any other income will be part of the review process. (Attach copies of <u>all</u> income statements, including SSI amounts.).

D. In requesting exceptions, the same documentation must be included in the request that is required to be submitted for the original request.

2. *APPROVAL PROCEDURES*

When requesting local IFS-R ~~family support funds~~ the DSN Board's family support staff will review materials submitted (or return for additional information) and make a recommendation with final approval/disapproval by the Executive Director or Designee.

3. *PAYMENTS*

A. The original Form #351, *"Individual and Family Support Respite - Request for Payment"* for the approval period including the approval amount shall be included with request when application is submitted. A separate Form #351, *"Individual and Family Support Respite - Request for Payment"* shall be completed for <u>each month</u> of payment if on-going. DSN Boards/Providers will pay vendors directly when possible and only to families on an exception basis.

B. Any unspent funds should be returned to the DSN Board/Provider for reallocation as soon as it is determined that all of the funds are not needed.

4. ***MONITORSHIP AND REVIEW***

A. ~~Once awarded the IFS, t~~The receipt of service use of IFS-R must be monitored by the SC/EI. Consumers receiving Level II service coordination should be monitored by guidelines in the ~~SC~~DDSN Policy. For those receiving Level I service coordination, the ~~service coordinator/early interventionist~~SC/EI must monitor on-going service provision at least quarterly to determine the family's satisfaction with the amount, frequency, and duration of the service provided. Verification of receipt of services must be completed by visiting the consumer during the time of the service or by reviewing attendance records/service reports.

B. The ~~service coordinator/early interventionist~~SC/EI must visit the consumer/family to verify receipt of any one-time item that was to be purchased. If during the visit it is determined that the stipend was not used as requested or pay a specific bill this should be documented and future requests should include such historical information. The ~~service coordinator/early interventionist~~SC/EI should notify the Executive Director/CEO of inappropriate use of funds. The Executive Director/CEO should then take the necessary steps to recoup funds.

C. If at any time the ~~service coordinator/early interventionist~~SC/EI determines that the need of IFS-R is no longer justified, then he/she must notify the person approving the request and on-going funds must end.

D. If at any time should a DSN Board/Provider revise its current Family Support Policy, it must forward a copy to the applicable District Office (who will forward to Central Office) for review and approval.

Kathi K. Lacy, Ph.D.
Associate State Director-Policy
(Originator)

~~Robert W. Barfield~~Beverly A.H. Buscemi
State Director
(Approved)

To access the following attachments, please see the agency website page "Attachments to Directives" under this directive number.

Form 350 – Request Form – Individual and Family Support Stipend/Respite
Form 351 – Individual and Family Support/Respite – Request for Payment

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

☐ MR ☐ RD ☐ Autism ☐ TBI ☐ SCI ☐ SD ☐ Other

REQUEST FORM—INDIVIDUAL AND FAMILY SUPPORT STIPEND/RESPITE

Consumer: _____

Local Provider: _____

DSN/Home Board: _____

Local Provider Action

Received Date: _____ **Review Date:** _____

☐ **Approved** **Amount:** $_____ **Approved Period:** _____

☐ **Denied (See reason below)** ☐ **No Action, Return to Referring Staff (See below)**

Comments: _____

_____

_____

_____

_____

_____

_____ _____

Local Provider Administrator **Date**

DSN/Home Board If Different From Above

Received Date: _____ **Review Date:** _____

☐ **Approved** **Amount:** $_____ **Approved Period:** _____

☐ **Denied (See reason below)** ☐ **No Action, Returned to Referring Staff (See below)**

Comments: _____

_____

_____

_____

_____

_____

_____ _____

DSN/Home Board Provider Administrator **Date**

Form #350 (Revised) July 2010

Provider Information

Referring Provider Staff: _____ **Phone:** (___) _____

Local Provider: _____

DSN/Home Board: _____

Consumer Information

Name: _____ **Age/Birth Date:** _____

Address: _____ **Phone:** (___) _____

_____ **Medicaid #:** _____

SS#: _____

Number residing in household _____

Members of Household: Relationship/Age

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Check All That Apply:

- ☐ **Medicaid Eligible**
- ☐ **Medicaid Eligibility Pending**
- ☐ **Community Choices Waiver**
- ☐ **Waiver Waiting List – Non-Critical**
- ☐ **Waiver Participation at home**
- ☐ **Waiver Enrollment Pending**
- ☐ **Waiver Waiting List - Critical**

Is the consumer currently employed? ☐ **Full-time** ☐ **Part-time** ☐ **No**

Monthly Household Income/Expense

(If additional space is necessary, attach worksheet to this form)

Income Sources	Amount	Major Expenses	Amount
		Essential Expenses	
		Housing	
		Utilities	
		Food	
		Car Loans	
		Non-Essential Expenses	
		Loans	
		Credit Cards	
		Cable/Cell Phones	
		Recreational/Other	
Total Monthly Income (Attach copy of Income verification)		**Total Monthly Expense**	

Net Balance (Income minus Expenses) $_____

(Describe how Consumer's SSI Income is used) _____

I certify that the above consumer information is true and complete. I understand that submitting false information or use of Individual and Family Support Funds or respite for purposes other than as requested may result in termination of assistance and a payback of expended funds to DDSN.

_____ _____

Consumer or Parent or Legal Guardian **Date**

Request Information

Type Request	Amount Needed	Amount Requested	Approval Period
☐ One-Time	$_____	$_____	_____
☐ Ongoing *	$_____	$_____	_____

*(Provide detail information about costs of items requested.)

Justification

Explain how out-of-home placement will be avoided unless request is for temporary funding while awaiting critical placement. Explain what the child/individual does during the day and if he/she is in school.

_____

_____

_____

_____

_____

Assurance of Resource Review

Other resources utilized/contributed to assist with requested need:

☐ **Consumer/Family** **Amount** $_____

☐ **Private Insurance/Medicare/Medicaid** **Amount** $_____

☐ **Private, Non-Profit (Specify)** _____ **Amount** $_____

☐ **Public Agency (Specify)** _____ **Amount** $_____

☐ **Social Security PASS (Plan for Achieving Self Support)** **Amount** $_____

☐ **IRWE (Impairment Related Work Expense)** **Amount** $_____

☐ **Other (Specify)** _____ **Amount** $_____

_____ _____

Referring Provider Staff **Date**

_____ _____

Reviewing Supervisor **Date**

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Individual and Family Support/Respite - Request for Payment

SECTION A: PAYEE INFORMATION

Payee: _____

Address: _____

_____

SECTION B: PAYMENT INFORMATION

Payment Month: _____

Payment Amount: $_____

Check one:

_____One-Time Payment

_____Monthly Payment (PO Required)

Purchase Order Number: _____

Vendor Number: _____

SECTION C: APPLICANT INFORMATION

Applicant's Name: _____

Applicant's SS#: _____

Description of Service: _____

SECTION D: AUTHORIZATION

I hereby certify that all information is true and applicable.

_____ _____

Signature of Executive Director/Designee Date

*When payments for the calendar year total $600 or more and are made directly to a provider of service operating under a social security number, a 1099 statement will be issued to the provider of service for tax reporting purposes.

Form #351 (Revised) July 2010